The Governor's Task Force on Improving Mental Health Services and Crisis Response
January 7, 2014

I applaud Governor McDonnell and Governor-elect McAuliffe's willingness to create and support the work of this Task Force to improve mental health services in the Commonwealth.

In the summer of 2011, my former agency, the Office of the Inspector General for Behavioral Health and Developmental Services (OIG), first heard the term *streeted*. This term was used to describe a person who had been evaluated and found to meet criteria for temporary detention but, instead of being admitted to a psychiatric hospital for further evaluation, a *streeted* person was released without the clinically indicated intervention.[1]

In the months that followed, the OIG polled the Commonwealth's CSBs to learn if *streeting* was limited to Hampton Roads or if it occurred in other regions of the state. The anecdotal information we received in response to our informal survey supported the conclusion that approximately 200 people had been *streeted* during the preceding twelve months.

The results of our poll led to a three-month statewide study of the state's 40 CSBs that was conducted jointly with the Department of Behavioral Health and Developmental Services (DBHDS).

This joint study documented that, during the 90 days between July and October 2011, Virginia issued approximately 5,000 Temporary Detention Orders (TDO). Of the 5,000 TDOs, 72 individuals (1½%) meeting criteria for a TDO were denied access to the clinically indicated inpatient psychiatric treatment. In addition, the study found that 273 individuals (5½%) were granted detention orders, but only after the six-hour time limit imposed by the *Code of Virginia* (*Code*) had expired. These and other findings, along

[1]The criteria for involuntary temporary detention are set forth in the *Code of Virginia* at § 37.2-809(E) "… to determine whether the person meets the criteria for temporary detention, a temporary detention order if it appears from all evidence readily available, including any recommendation from a physician or clinical psychologist treating the person, that the person (i) has a mental illness and that there exists a substantial likelihood that, as a result of mental illness, the person will, in the near future, (a) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any, or (b) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs, (ii) is in need of hospitalization or treatment, and (iii) is unwilling to volunteer or incapable of volunteering for hospitalization or treatment."

with 13 recommendations, were published in the *OIG Review of Emergency Services*, Report No. 206-11, dated February 28, 2012.

This means that almost 1,400 people a year could be expected to either be denied a access to clinically appropriate care or granted a TDO after the six hour time limit. Not to put too fine a point on it, but based on this review, every day three to four people will experience this outcome in the Commonwealth.

It is worth noting that the recently completed study by the University of Virginia (UVA), Institute of Law and Public Policy in December 2013 documented marginally "worse" results than the 2011 OIG findings. This recent UVA study found that a TDO was issued to 96.5% of the individuals meeting TDO criteria and that 95.2% of persons recommended for a TDO "were eventually admitted to a mental health facility."[2/3]

The UVA study also documented that, "…almost one of every five adults (18.2%, n=624) was under the influence of drugs or alcohol, and another 5.2% (n=180) were suspected to be under the influence." This finding has important implications for determining if a person should be admitted to an acute care facility for evaluation and treatment or transferred to a facility for detox services.

Some behavioral health topics can appear byzantine; full of indecipherable acronyms only accessible to subject matter experts, and beyond the reach of people who do not work in the field; however, the solutions to *streeting* are straightforward but, to be effective, all solutions will require consensus around a core value.

That core value is that every person with mental illness, who is evaluated by a preadmission screener and determined to meet criteria for a TDO, is admitted to a psychiatric facility.[4]

As long as we are willing to accept that any person with mental illness, who has been found to be a danger to self or others – and lacking the capacity to protect him/herself from harm, can be released without hospitalization—where hospitalization is clinically indicated, the Commonwealth will continue to *street* people and experience some unknowable number of preventable tragedies.

[2] *A Study of Face-to-Face Emergency Evaluations Conducted by Community Services Boards in April 2013*, Institute of Law and Public Policy, University of Virginia, 2013. http://www.law.virginia.edu/pdf/news/face_to_face_emergency_evaluations_report_v2.pdf

[3] UVA's study sample universe included all emergency evaluations; unlike the OIGs study sample that limited its focus to those people who had been evaluated and determined to meet criteria for temporary detention. Therefore, these two studies may not represent an apples-to-apples comparison**.**

[4] The *Virginia Preadmissions Screening Form* (01-22-13 Version) can be found on the DBHDS website at: http://www.dbhds.virginia.gov/documents/forms/Preadmission%20Screening%20Form%2001-22-2013.pdf

Again, unless and until the Commonwealth endorses a zero tolerance for *streeting*, this dangerous practice will continue; however, if we collectively agree that *streeting* will not be tolerated in Virginia, it can quickly be eliminated from the mental health landscape and lexicon.

During my travels around the state and countless discussions with emergency services managers, preadmissions screeners, emergency room physicians, and CSB executive directors, I have heard many ideas that, if implemented, would end the practice of *streeting*. Most of those ideas are contained in the 2012 OIG Report and many have been restated in Secretary Hazel's December, 2013 Report and Governor McDonnell's Recommendations.

There is no shortage of good ideas. I challenge the members of this Task Force not to be satisfied with the status quo. Instead of asking "What is?" I challenge you ask, "What could be?" and "What should be?" For example:

- The 2012 OIG Report and Secretary's Hazel's Report to the Governor both mention the electronic Bed Registry as a possible way to reduce the time required to locate an appropriate bed for someone in a psychiatric crisis;[5] but the naysayers quickly observe that the Bed Registry will only work if private psychiatric hospitals promptly update the Registry.

  Given the stakes, there is no good reason why private providers should not promptly update a Bed Registry and post the available beds in a forum accessible to all prescreeners. If necessary to accomplish "what should be" instead of "what is," the regulations could be revised to make timely participation in the Bed Registry Program a condition of licensure for psychiatric hospitals.

- State-operated hospitals employ hundreds of staff at each facility. Could one person in each of the state's behavioral health facilities function as a psych bed clearinghouse – a "bed-broker" if you will – for the dozens of preadmission screeners serving each of the state's seven planning regions?

- *Streeting* could be ended the day after revising *Code* § 37.2-809 (E). Currently the *Code* requires the receiving facility be listed on the preadmission screening report and the temporary detention order. This could be changed to reflect that the individual "will be detained at a location to be determined"—instead of the current requirement to identify the receiving facility in order to execute the TDO.

[5] *OIG Review of Emergency Services,* Report No. 206-11 (pg. 25).
http://www.oig.virginia.gov/documents/SS-EmergencySvcsReview206-11.pdf

- *Streeting* could be greatly curtailed if Emergency Custody Orders (ECO) could be reissued following expiration. My understanding is that the reason a new ECO is not issued following the expiration of the first ECO is rooted in a 15 year-old Attorney General's *Opinion*. If true, this *Opinion* could be revisited for current relevance or revision to the *Code*.

- Authorize, and require, the Commissioner of DBHDS, or his designee, to direct placement of any person meeting criteria for temporary detention in any state-operated hospital if a private facility cannot be located for that individual.

This list of effective actions undoubtedly can be expanded and improved, if Virginia embraces the value that no person meeting TDO criteria will be released as long as they meet the statutory criteria for involuntary detention.

Obviously, revisions to the *Code* will not happen overnight, but there are actions that the Commonwealth can, and should, undertake with all possible dispatch. We cannot rewrite history and retrospectively implement the OIG's February 2012 recommendations, but we can take decisive action on some items that will make a difference. Two such items requiring immediate attention include:

1. Complete updating the *Medical Screening and Assessment Guidance Materials* as quickly as possible. This workgroup last met on **December 11, 2012**. In a December, 2013 meeting with Emergency Services Managers and conversations with Emergency Department physicians, medical clearance remains one of the most time consuming, and unpredictable, aspects of the preadmissions screening process.

2. DBHDS can provide clear operational protocols to all CSBs that include an unequivocal policy statement that every person in a psychiatric crisis will be treated at the appropriate level of in-patient care: *streeting* is an unacceptable outcome in Virginia.

As profoundly sad and shocking as the events of November 19, 2013 were, this tragedy represents a symptom of the underlying problem with the Commonwealth's behavioral health system.

The underlying problem is that Virginia currently lacks the capacity to serve its citizens with mental illness and, unless we increase the system's capacity, this tragic outcome will be repeated.

No one credibly disputes that Virginia needs more community-based behavioral health programs, including permanent supported housing, for individuals with mental illness.

At the same time, the Commonwealth also needs to use its existing resources more efficiently. For example, the state-operated facilities continue to serve people that have been determined to be discharge-ready. These are individuals who could be discharged and return to their communities if the community-based programming and housing existed to serve them. At least 10% of the state facility psychiatric beds continue to be occupied by people who could be served in the community.[6] When facility beds are occupied by discharge-ready people, some state facilities will be unable to admit people in need of acute care for temporary detention because they are at capacity.

Speaking of capacity, I recommend that the Task Force inquire into why the state operated behavioral health facilities had an operating capacity of 1,487, but a census of 1,200 as of September 12, 2013.[7] Further, according to the December 2013 update of the *Comprehensive State Plan*, "In FY 2013, state facilities served 5,772 individuals, down from 6,238 in July 2012 and 6,338 in July 2011." (pg. ii)

As the Commonwealth's public sector system has been operating, at least 10% of the state facility beds are occupied by people who could be discharged into the community and approximately 20% of the operating capacity went unused on September 12, 2013. With roughly a third of the system's facility capacity either unused or used for people deemed discharge-ready, it is not surprising that the state facility system served about 10% fewer people in FY 2013 than it did two years earlier. Three obvious questions arise:

1. Does anyone believe that there is 10% less acuity in the Commonwealth's mental health system today than there was two or three years ago?

2. Has the DBHDS's cost for facilities operation gone down by 10%? and,

3. Has the budget for community mental health been increased by 10% since 2011?

As the *Barriers to Discharge Report* observed, the component parts of Virginia's mental health system are interdependent. When state-operated facilities are at capacity, people needing acute and long-term care can be denied admission to those facilities. Likewise,

[6] *Review of the Barriers to Discharge in the State-Operated Adult Behavioral Health Facilities,* OIG Report No. 207-12, April 2012. http://www.oig.virginia.gov/documents/Syst-Rev-207-12.pdf
[7] *Comprehensive State Plan 2014-2020*, Virginia Department of Behavioral Health and Developmental Services, pg. i. (December 2013). http://www.dbhds.virginia.gov/documents/reports/opd-StatePlan2014thru2020.pdf

when community-based programs are insufficient to allow for the timely discharge of individuals from state hospitals, and individuals must remain involuntarily committed for months, or years, after being determined ready for discharge, then the state-operated facilities may not be able to admit people in desperate need of acute or long term care.

There is cohort of individuals with mental illness who move between the community and facility systems of care. When community capacity is insufficient to absorb the individuals released from state hospitals and state facilities erect barriers to admissions, (like the requirement to call 8, 10, or 15 private facilities before seeking a TDO admission in a state hospital) the people in need of acute care will be directed to private psychiatric facilities—or will end-up in our local and regional jails.

Since 2008, the number of individuals identified with mental illness in jails has increased by 30%, from 4,879 to 6,322.[8] Each year, several thousand people with mental illness move among community-based programs, state-operated behavioral health facilities, and local or regional jails.

In its 2012 *Review of Emergency Services*, the OIG observed that, every time a person meeting criteria is denied temporary detention, it represented a failure of the system and placed that person, their family and their community at-risk.

Another preventable human tragedy waiting to happen in the Commonwealth will occur when a person is released from a private psychiatric facility after a brief period of hospitalization for acute symptoms, with a discharge summary reflecting that, “this person has received maximum benefit from this hospitalization.”

The unspoken part of this discharge summary will be that the state-operated facility has denied admission for the patient and the private provider has no reimbursement path for the continued hospitalization of this individual. When the transfer of patients to state operated facilities for long-term care is not an option, private providers must choose between either not being paid for services or discharging the individual.

If the regional state facility creates barriers to admission and there is no clear path to reimbursement for services rendered, it should come as no surprise that some private providers will avoid admitting a person under a TDO who might require long-term treatment—treatment for which they may not be paid.

In conclusion, during this presentation, I have chosen to use the term *streeted* (instead of failed-TDO) because it is shocking. The term offends our sensibilities, and our common sense, when a person meeting statutory criteria for hospitalization is allowed to

[8] Comparison of the 2008 and 2012 Compensation Board Report on Mental Illness in Jails.

leave an emergency room following an evaluation concluding that he, or she, is in need of hospitalization.

I will never forget where I was when the media reported that Gus Deeds had attacked his father and had taken his own life after a bed could not be found to execute a temporary detention order. I sobbed at the news—and, honestly, for days after. I will always wonder what I could have done differently in the last two years to shed more light on *streeting* that may have produced a different outcome on November 19, 2013.

I recommend that the Task Force consider how it will ensure that its recommendations are actually implemented and to directly address the issue of accountability in its Report to the Governor and the General Assembly.

My hope is that the Task Force will be focused by recent events to identify and finally address the underlying capacity problems with the Commonwealth's system of care for its citizens with mental illness—so that no family ever has to experience what the Deeds family is going through.

Thank you for the opportunity to speak with the Task Force today. I remain,

Sincerely,

/G. Douglas Bevelacqua/

G. Douglas Bevelacqua